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Transformations of Intimacy and Sociality in Anorexia: Bedrooms in Public
Institutions

Abstract

Anorexia can be characterized as a profound transformation in social relations. These transformations occur across a number of overlapping fields, and include a range of institutional and domestic spaces and the myriad of mundane bodily practices in each. Through an examination of household space and a conventional treatment program this paper demonstrates the ways in which people with anorexia use and transform space. While there are many treatment programs available for those with a diagnosis of anorexia, the ethnographic focus here is on those who have undergone bed programs in public hospitals. As a result of the particularities of time and space, these rooms are transformed into intimate spaces that represent domestic bedrooms, thus fundamentally changing the nature of shared space in institutionalized settings. These transformations, however, are not straightforward, for these bedrooms fuse a number of bodily practices (such as eating, sleeping and abluting) that are sharply demarcated in domestic architecture. In these hospital bedrooms, private and public space is conflated, reversed and made ambiguous. Moreover, this paper argues that this institutional transformation of space reproduces many of the private practices associated with anorexia, a factor which has been overlooked in the recorded failure of these types of programs.

Anorexia is defined as 'an expression of a woman's confusion about how much space she may take up in the world'. (Orbach 1986:14)

Introduction

Much of the critical and feminist literature on anorexia nervosa draws upon the work of Foucault to throw light on the ways in which discourses such as medicine and gender are fundamental to understanding the operations of power and knowledge in the production of disciplined and docile bodies. Foucault's theory of discourse has been highly influential and productive in this field because it provides a critique of medicine, and by extension, of patriarchy. Writers such as Turner (1984, 1987), Bordo (1988, 1989, 1990), Bartky (1988), Tait (1992), Eckerman (1997), Hepworth (1999) and Malson (1998) all argue in some form or another, that the most common reason for eating disorders is that constructions of femininity, a pre-occupation with diets and exercise promulgated through the media, and institutional control and regulation of individuals, have constituted these disorders.

A small number of writers in this field (Bartky, 1988; Eckerman, 1997; Malson, 1998) have extended Foucault's insights of the architectural design of hospitals into psychiatric wards and their relationships to social control. Eckerman, for example, in her work with women with anorexia, notes the irony of architectural design in eating disorder units. Those in treatment programs were constantly surveilled as 'the rooms chosen for those undergoing behaviour modification were within sight of the nurses station, with glass panels internally and large windows to the outside to allow uninterrupted vision. All meals, showers and toileting were carefully supervised'

(Eckerman, 1997: 157). This was Bentham's panopticon par excellence, and the interchange between prisons and inmates, hospitals and inpatients has not gone unnoticed, as Bartky, reading from Foucault writes:

Each inmate is alone, shut off from effective communication with his fellows [sic], but constantly visible from the tower ... In the perpetual self-surveillance of the inmate lies the genesis of celebrated 'individualism' and heightened self-consciousness that are hallmarks of modern times. (Bartky, 1988: 63)

While not denying the use of power within medicine or the profound influences of Foucault's work, this paper differs from these Foucauldian approaches to anorexia and institutional spaces. My aim (akin to Gremillion 2003) is to extend and complicate widely used Foucauldian analyses by challenging the many polarised oppositions that are to be found in this body of literature (of docile or resistant bodies, and of public or private spaces).

In earlier works on self-starvation, the 'anorexic body' is read as a metaphor for the social body — as Bordo's title explicitly states, a 'crystallisation of culture' (1988).¹ The body of these analyses, which reproduces the docile body that Foucault articulated, is a text in which cultural values are inscribed, etched and written upon.² Power relations 'have an immediate hold on it; they invest it, mark it, train it, torture it, force it to carry out tasks, to perform ceremonies, to emit signs' (Foucault, 1977: 25). The particular use of Foucault's discourse has rendered the gendered body malleable, one which 'locates the generative forces outside the immediate, lived reality of the lifeworld' (Jackson, 1996: 21; cf. McNay, 1999).

This passivity of the body is, in part, a result of the way in which discourse and its operations of power and knowledge have been located by these writers in specific

institutional practices – in hegemonic and dualist structures that allow little room for analysing the everyday spaces of anorexia. This is in spite of Foucault's own theoretical shift in understanding power from institutions to the self.³ Turner (1984), for example, demonstrates this hegemony at work:

Anorexia is ... a symbolic struggle against forms of authority [patriarchy, family and medicine] and an attempt to solve the contradictions of the female self, fractured by the dichotomies of reason and desire, public and private, body and self, nature and culture. (Turner, 1984: 201)

Such an analysis, not only accommodates structuralist (and hence disembodied) accounts, but also, as McNay suggests, tends to position 'disciplinary power as a fully installed monolithic force which saturates all social relations' (McNay, 1994: 104),

In attempting to acknowledge the shifts in Foucault's theories of power, recent analyses of power within the field argue that anorexia is not an extreme extension of patriarchal ideals, but an active, oppositional practice to 'normative' femininity.

Anorexia is characterised as an act of resistance against dominant, hegemonic discourses, and its use is a productive, rather than a repressive force (Eckerman, 1997: 157-8, Grosz, 1994: 40). While focusing on resistance allows room for agency on the part of those in subordinate positions of power, resistance and power still remain as polar opposites, rather than configurations that work in multiple ways. This positioning of resistance in a dualist framework falls prey to what Abu Lughod refers to as a 'romance of resistance' (1990), in which defiant acts are heroicised. As Grosz argues, the line between compliance and subversion is always a fine one (Grosz, 1994: 144).

Another important distinction this paper makes in regards to extending Foucauldian accounts of anorexia, is to problematise the common sense dichotomy of public and private space. Analyses of space that adopt Foucault's panoptican understanding, whilst acknowledging the pervasiveness of this gaze, tend to focus on institutional (Eckerman, 1997; Gremillion, 2003) and public space (read as community spaces) (Malson, 1998).⁴ An analysis of everyday, intimate spaces is overlooked. Drawing on Duncan's (1996) critique of binary spaces, this analysis does not take for granted the familiar spatial division between the domestic and institutional. Rather, it examines how these spaces are subject to a remapping through a blurring of embodied practices, highlighting the myriad and complexity of spaces in which bodies constantly move.

Rather than use a structuralist or discursive analytic framework, it is through the lens of embodiment that intersections of spaces, bodies and power are examined. Informed by anthropological analyses of space, place and gender (Bourdieu, 1977; Carsten & Hugh-Jones, 1995; Low & Lawrence-Zuniga, 2003), and feminist geographies (Duncan, 1996; Longhurst, 2001; Butler & Parr 1999), the analysis examines the multiple ways in which people with anorexia embody different architectural spaces, that is, how they create, reproduce, reconfigure and disrupt spaces. I trace the ways in which spaces are transformed by participants in their own homes, arguing that these transformations are reproduced and contested in institutional spaces, yet with entirely different consequences. This analysis does not segregate spaces, but closely examines the ways in which the domestic and institutional collapse and constantly refer to each other. Central to this relationship is the understanding that space needs to be understood not simply as a geographical place, but as 'a space of relations', a complex

and sometimes contradictory arena of potential struggle for ‘symbolic power’ (Bloustein, 1999: 117).

The study

Surprisingly, there are few ethnographies of anorexia, and the fieldwork that has been done has been institutionally focused (cf. Gremillion, 2003). Considering that many of the participants in this research project spoke of a consuming desire to ‘fade away’, ‘disappear’, ‘dissolve into thin air’ and ‘fit into a matchbox’, it is even more surprising that there are few spatial analyses of embodiment in anorexia. Ethnography is ideally placed to explore these interactions of spaces and bodies, as it does not rely solely on textual data as discursive analyses often do,⁵ but attends to what Bourdieu (1977) refers to as the embodied, spatial practices of everyday life — the *habitus*.

It was ethnographic fieldwork (of extended interviews and participant observation) with 46 people diagnosed with anorexia (44 women and 2 men, aged between 14 and 55) that enabled me to share in participants’ everyday worlds.^{6,7} My fieldwork sites (Vancouver, Edinburgh and Adelaide) took me to a variety of treatment settings (in-patient and out-patient units in public and private institutions, community treatment programs), community education centres (eating disorder associations and support groups), and into people’s own homes and everyday spaces. I spent many hours with participants in their kitchens, lounge rooms, and bedrooms, shared food and drink, met with families and friends, and accompanied them into their community spaces.

As anorexia is often a long term condition, many participants had established relationships with mental health care providers and were admitted to (and discharged from) eating disorder programs during the fieldwork. With their consent, I continued to meet with them during their hospitalizations, ate with them in communal dining rooms, sat in on ward rounds and therapeutic sessions, interviewed those involved in treatment teams (including psychiatrists, nurses, dietitians, psychotherapists and art therapists), read case notes and closely examined the day to day routines of ward life.

It was via this engagement with people in their everyday lives that I was able to understand anorexia⁸ through both spoken and written language and what Desjarlais refers to as a ‘phenomenology of embodied aesthetics’ (Desjarlais, 1992: 66). I watched the ways in which arms and legs were held close to the body, or folded neatly under torsos as participants sat in chairs, thus minimizing the consumption of space in an attempt to appear physically smaller and disappear. In addition, I drew maps of domestic and institutional spaces with participants, and asked them to take their own photographs of spaces, noting the horrified, recoiling bodily reactions of some to specific sites such as kitchens or open fridges, and the humour attached to photographing symbols of hospitalization (such as bedpans and meal trays).

These were the fields in which people traveled, these were part of their everyday worlds and experiences. As Lucas argues in his ethnography of people with schizophrenia, to ignore the interconnections between experiences and objects, between people and places, would be to explore only part of their worlds (Lucas, 1999: 108-109; cf. Parr & Butler, 1999: 12). My field sites, like the everyday worlds of participants, were not pristine, bounded or contained. People moved back and forth

between what Parr and Philo (1995: 211) refer to as a ‘mish mash of sites’ — of psychiatric services, community spaces, and domestic dwellings — each site a social space enmeshed in and generating its own representations, knowledges and powers (Bourdieu & Wacquant, 1992). It is thus impossible to speak of institutional spaces without referring to their relationships with other daily spaces.

Despite the relational aspects of these differing spaces, institutional spaces continue to be aligned with concepts of public, sharply divided from the private (and intensely gendered) realm of domestic spaces. Duncan argues that this hierarchical dichotomy is ‘deeply rooted in political philosophy, law, popular discourse and recurrent spatial structuring practices’ (Duncan, 1996: 127), in which public space is assumed to be exterior and open, and domestic space interior and closed. Bloustein similarly suggests that because the ‘attributes of space seem so self-evident, they are frequently categorized into private and public spheres as though these were neatly bounded areas that could be defined and understood objectively’ (1999: 128). As a result, there is little acknowledgement of the multiple ways in which these concepts operate. Within any hospital, for example, there is a myriad of private and public spaces — operating theatres for example, are the most closeted spaces of privacy that are never seen or accessed by the general public (unless of course they are undergoing surgery, and even then their memories of such spaces are anaesthetized). Nor are institutional spaces always hegemonic as suggested in Foucauldian analyses of anorexia (aforementioned). Institutions, as Saris (1995) argues in his critique of institutional assumptions within medical anthropology, not only control, reproduce and name, but are simultaneously sites where agency, meaning and power are created.

Reconfiguring spaces of relatedness

It is widely recognized that people with anorexia have a range of practices that significantly alter the ways in which they engage in social relationships. As Dias notes, ‘the early stages of anorexia are usually marked by extreme isolation, secrecy, and disconnection’ (Dias, 2003: 31). Social gatherings around food such as meal times, drinks with friends or any social event presents a level of anxiety that can only be circumnavigated by withdrawal. The isolation that results from negating social relationships was reflected amongst those involved in this study; many had reduced social networks and over a third lived alone. The most striking aspect of people’s lives was the absence of sexual relationships. Over seventy percent were single at the time of my fieldwork and not engaged in any sexual relationships and/or activities. In terms of relatedness, this is significant, for several described the difficulty of having ‘other’ and intimate relationships whilst ‘you were having a relationship with anorexia’. As Maddy, now recovered, said: ‘The place where anorexia is, it’s a very narrow space, and there is little room for anything else’.

As I have argued elsewhere (Warin, 2004) the negation of social relationships did not leave people in a void, but allowed the creation of new relationships with themselves, with the personified *Ana* or *Ed* (acronyms for anorexia and eating disorders), other people (often with the same diagnosis) and spaces. For those who lived with families or in share houses (and this was over half the group), living spaces were fundamentally transformed. Participants utilized spaces that were already signalled as private (bathrooms, toilets and bedrooms) to purge and hide food, and transformed shared social spaces (such as kitchens and dining rooms) into private spaces. When participants did enter kitchen spaces it was often on their own terms: alone and at a

time of their choice. Suzi remembers shutting all the doors to the kitchen in her family home – ‘so it was all private’ — and cooking cakes that she would then take hours to meticulously decorate. If her parents or younger brother came into the kitchen whilst she was making cakes she would lose her temper and scream at them, for to be disturbed around food, or ‘caught eating’ was tantamount to a grave invasion of privacy.

Closing off the kitchen and refusing to eat with the family created anger amongst Suzi’s family, so she simply refused to eat with them, or even allow them to prepare food for her. Negating family meal times was an affront to her parents, who were ‘believers in that saying “the family that eats together stays together”’. Suzi’s transformation of spaces within the family home had profound consequences for the taken for granted nature of social relations. Akin to Counihan’s analysis of food, intimacy and autonomy in a Florentine family (1999: 156-77), the places in which food was made and consumed was no longer symbolic of ties and connections, and it’s refusal a powerful act that ruptured and disconnected family relations.

Instead of eating with her family in the kitchen Suzi transformed the intimate space of her bedroom into the single space in which she stored, prepared, ate and expelled food.

I was buying in tonnes of food - my wardrobe was like stuffed with packets, and packets of crisps, packets and packets of biscuits, anything sweet - biscuits, cakes, ice creams - my wardrobe was stuffed full. My whole life was spent in my bedroom to be honest, that’s where I lived all the time.

As well as hiding food in the cupboards, she spat and vomited into plastic containers that were hidden under her bed. Her bedroom was not simply a place for sleeping, it was also a dining room, a kitchen, a pantry and a receptacle for bodily wastes.

Part of the retreat to the bedroom was related to the difficulty of sharing domestic spaces, of having to deal with the sociability surrounding food preparation and eating. Elise, the youngest research participant at 14, knew that her mother would 'go spare' (be angry) if she found her wearing rubber washing-up gloves in an attempt to avoid contamination from fats while preparing food. It was easier to avoid people and emotions by withdrawing to a bedroom. The history of the bedroom, as Lofgren (2003) and Epstein (1994) note, changed during the Victorian era with the development of the concept of individualism and privacy. Privacy in sleep and sexual intimacy of the married couple meant that the bedroom became the most private domain of the home (Lofgren, 1984/2003: 145), where seclusion of sleeping and sexual activity was marked in space. It was this seclusion and privacy of bedrooms in family homes and share houses that allowed participants to disconnect from others. Grant explained that his bedroom was a haven, a place where he could retreat:

I've always seen [the bedroom] as my place - I shut the door, that's it - it's my world sort of thing. My parents wouldn't come in there and I could have that space around me and be comfortable. So I'd go down there to retreat and get away from everyone else and that's when I started doing a lot of stupid food things eating in my room and chucking food away [into the waste paper bin], I saw my bedroom as a safe place to do that.

Bathrooms and toilets were similarly private spaces, and these were sometimes transformed into eating spaces. Lara discussed the difficulty of sharing a house with another woman, outlining her strategy of taking food to the bathroom. Late at night she would take one apple from her ‘stash’ — the ‘mountain of apples’ in her bedroom — to the privacy of the bathroom, avoiding the commensality of eating. It was not only a transformation of spatial practices, but also of time, for she ate only late at night when the darkness of the house ensured absolute privacy.⁹

As I have argued in accompanying papers on bodily contamination, hygiene and anorexic practices (Warin, 2003a & b), bathrooms, kitchens and bedrooms are key sites in everyday experiences of anorexia. These are abject zones (cf. Longhurst, 2001:132; Kristeva, 1992) in which the materiality of the body is laid bare and opened. In each the body’s permeability is heightened via the ingestion of foods (in kitchens), the expulsion of wastes (in toilets/bathrooms) and the exchange of bodily fluids (in bedrooms). Bodily boundaries are transgressed and the cultural logic of the ‘clean and proper body’ (Grosz, 1994: 194) is threatened.

Through their remapping of domestic spaces, participants blurred the practices of sociality and privacy that one would normally associate with each of these domestic spaces. And it was precisely these re-configurations of space that supported anorexic practices, for it allowed participants to remove themselves from the surveillance of family and friends. They could eat alone (and what they chose to eat), hide and discard food without recrimination, and purge unwanted food in order to cleanse their bodies of contaminating foods. Clearly hospital programs attempt to prevent some of these well known ‘anorexic behaviours’, but as the next section argues, the spaces of single

side rooms that are the mainstay of in-patient treatments actually reproduce and support these facets of anorexia.

Re-creating bedrooms in institutional spaces

While there are a multitude of treatment programs for people with anorexia (ranging from in-patient, residential, community, out-patient and so-called ‘alternative’ modalities), the hospital based programs I engaged with, although they varied in specific content, were remarkably similar in design and instrumentation. Those who were admitted to in-patient programs always met a criterion that warranted hospitalisation (most often dangerously low weights that had immediate consequences for health) and were ‘confined’ to hospital beds to conserve energy and gain weight. In line with Eckerman’s (1997: 157) earlier observations, single side rooms for in-patients were positioned directly opposite the nurses’ stations, and the occupants of each room could be observed around the clock. Doors were not allowed to be closed (although curtains could be used for privacy when patients needed to wash or go the toilet). These admissions were voluntary (although often sparked by family pressures) and patients signed contracts to which they conformed or were asked to leave. Contracts were often broken, with the main reasons being a vehement resistance to weight gain; frustration of intense surveillance (and strict guidelines for mealtimes, activities such as showering, and visiting hours); boredom; hiding food, and secretly exercising. The programs varied in length (from 2 weeks to 6 weeks), and participants had often done successive programs over the years.

Whilst establishing relationships with health professionals prior to my fieldwork entry a psychiatrist asked me if I’d like to meet some of ‘the girls’ with anorexia on the

ward. He specifically wanted me to see how these hospital rooms had been transformed into what he called ‘bedrooms’. While these rooms were striking in their difference to others on the ward, it was not until I had spent time with participants in a variety of spaces that the significance of these transformed bedrooms took hold. In one psychiatric ward the single side room (of four square metres) conflated all spaces: it was the bedroom, the bathroom/toilet and the place where patients ate. As such it was a site that was profoundly ambiguous and confusing, for it was a private side room, yet located in the most public of spaces. I noted this conflation in my fieldnotes at the time:

There was something ‘odd’ about the space of Elise’s single room. On the psychiatric ward of this major public hospital there are 8 beds dedicated to patients with eating disorders. Those who sign contracts with the staff to do bed programs are allocated a single room - a room which contains a bed, a side locker and a cupboard. Nearly all patients transform these rooms into bedrooms - Elise’s room, for example, was heavily decorated with posters of *Silverchair*¹⁰ on the walls and doors, many cards and letters (some from a friend with anorexia whom she had met in hospital and who was also a participant in my research), photographs of school friends, craft pieces, puzzles, a radio cassette player, a television, candles, gifts from visitors including dried bunches of hanging flowers (arranged in a line above her bed). Her parents had brought in her pillows and duvet from home, adding the final touch of transformation. Like many high-rise buildings, the windows do not open, and the view is of the bricks of the adjacent building. There is a sink, but it has no taps and the plumbing underneath has been removed. This is to ensure that patients cannot vomit or throw food down the sinks. The door to

the ensuite bathroom is locked for the same reason, and patients are brought bedpans to use on a chair. The door to the room should remain open at all times so if you were to be surreptitiously exercising you would be seen and given a warning and the only time it can be shut or the curtain pulled across is when you need to use a bed pan. Activity is restricted to a minimum and bed rest is encouraged. The single room thus becomes the bedroom, the bathroom/toilet and the place where people eat - it is a conflation of what is otherwise sharply demarcated in the private and public spaces of suburban homes.

However, it was not simply a reversal of the public/private dichotomy, of the private lives of patients becoming public, but a conflation of practices and spaces: for what was deemed private became public and what would normally be associated with sociality, became private. This conflation was demonstrated when I was asked by a female staff member to leave a participant's room whilst she ate her lunch. I hurried after the psychiatric nurse to ask her the rationale behind the request, as the only times that I had ever been asked to leave a room in a hospital was when someone needed to do something that was deemed 'private', such as using a bedpan or having part of their body attended to (an open wound dressing or an invasive bodily procedure). The nurse explained that eating alone was a stipulation of the bed program for it allowed Amanda to concentrate on the task of eating with no competing distractions. She referred me to dot point 8 of the contract that Amanda had signed, which read: 'No-one will be present while the patient is eating meals. Meals must be eaten before visitors can be seen and must be completed within 30 minutes. TV and radio to be switched off while eating'. The single side room thus created a stage for reproducing

many of the spatial configurations and social relations that were practiced at home to support anorexia.

Although space is not a focus of her analysis, this reproduction of anorexia's conditions of possibility are highlighted by Gremillion (2003) in her recent ethnography of a psychiatric program for adolescents with anorexia in North America. In her analysis of therapeutic processes, Gremillion similarly argues that psychiatric treatments unwittingly participate in and reproduce culturally dominant ideals of gender, individualism, and family life that are so central to anorexia (cf. Moulding, 2004). The psychiatric team for example, becomes the substitute therapeutic family which takes over traditional gender roles that are assumed to be pathogenic in the causes of anorexia. These pathogenic family relations, as Malson notes, are reported to be 'typical [of] anorexic families' and consist of certain personalities or behaviours (such as dominant mothers, passive fathers, and sibling rivalry) (Malson, 1998: 84-89). Over involved mothers and absent, authoritative fathers are reproduced in a clinical setting through gender hierarchies of staff. As in my fieldwork, most psychiatrists in eating disorder wards are older males, and hold dominant positions of power within the therapeutic family. The majority of nurses, who are intensely involved in the day to day care of people with anorexia, are women. The therapeutic family thus acts as a substitute family, unwittingly reproducing the very family that it assumed to be at fault in the underlying pathology of anorexia. Similarly, the intimate surveillance of bodies on bed programs (through daily weigh ins, measurement of urine and calorie counting) is enacted by both staff and patients, with some patients becoming 'better practiced anorexics' through their hospital stay (Gremillion, 2003: 10).

In arguing that treatment teams participate in the reproduction of anorexia, it is important to highlight that this is not a straightforward mapping. As in any cultural reproduction there are tensions and transformations. Participants may have transformed their ward rooms into bedrooms, but as already highlighted, the privacy associated with the private single room was a misnomer for they were constantly and intimately surveilled by staff. There are, however, subtle and important differences between the hegemonic rendering of Foucault's panopticon and acts of resistance to this surveillance. One participant, who at 44 years of age hated 'being treated like a child', crawled on her hands and knees out of her room, along the floor on the other side of the nurses' station, and to the smoking room down the corridor so she could have a cigarette. The fact that participants had to eat *all* food that was presented to them (or risk a warning), that they couldn't use the plumbing in their rooms, or wash their hands after touching food, set up anxieties against which they rallied. Many laughed with me about how they had tricked the staff through tactics akin to de Certeau's (1984) *la perroque* – hiding food in the ceiling panels, draining apple juice into bed pans that were taken away and disposed of by the nurses, and scraping butter between newspaper sheets or duvet covers. In subordinate positions of power, participants strategically worked within established spaces and networks to appropriate their own power. This creative and resistant act belie the 'docile bodies' that are emphasised in Foucault's work and is akin to Battaglia's (1997: 507) and Desjarlais' (1996) notion of agency play, in which people, in the continual negotiation of their everyday lives, appropriate and transform power according to the context and struggles at stake.

However, in characterizing these spatial tactics as a way of obscuring power relations, one should not fall into a 'romance of resistance'. Gremillion illuminates Abu-Lughod's point in arguing that resistance through anorexia does not occur straightforwardly as an heroic reaction to medical dominance. Rather, she reveals how, in her field site, resistance was part of a 'diagnostic of power' and was actively nurtured by the treatment team in therapeutic protocols. Opposition to treatment was viewed as a positive step in progress as it indicated a shift in patients from 'mousy and compliant ... to arguing the fine points of their program and resisting you tooth and nail ... [and finally] they start getting better, because they decide it's not worth their time to hang out in hospital and talk to us' (Gremillion, 2003: 48-49). If however, one was to extend Gremillion's argument, the power of resistance that people with anorexia garner is, in Bourdieu's terms, 'misrecognised'. As Gremillion herself argues, those who use anorexia as a form of resistance are ultimately self-defeated (2003: 47) because they participate in a field of symbolic power in which they are always disadvantaged.

Being confined to a bed program reinforces gendered associations of space in which women, who were often referred to as 'girls' in ward rounds, are isolated and restricted from participating in social networks. Ardener, in *Women and Space* (1993) argues that 'the organisation, meanings, and uses of space express the hierarchy of social relationships and ideologies encoded in it' (Ardener, 1991, quoted in Low and Lawrence-Zuniga, 2003: 9). Restricting women to bed programs, in which there are strict guidelines for physical movement, visiting, and social interactions with staff and other in-patients), positions them squarely within relations of power in which they are effectively muted.¹¹

As such, this confinement to space can be likened to Sedgwick (1990) and Brown's (2000) use of the closet metaphor in their analysis of gay oppression. The closet, Brown argues, is a metaphorical and material space that works as a site of oppression and resistance, in which people lie, hide, are silenced, unseen and 'come out of' in order to exist. Certainly for people with anorexia, the need to conceal and deny their everyday practices is an important element of maintaining anorexia, and for hiding behaviours that are readily pathologised (such as self-induced vomiting or laxative use). In order to continue closeted 'anorexic behaviours', participants retreated to bedrooms, toilets (water closets) and bathrooms.¹² Like the bedrooms in institutional spaces, these closetted spaces are coded as feminine and 'employed to exclude, control, confine and suppress gender and sexual difference preserving traditional patriarchal and heterosexist power structures' (Duncan, 1996: 8).

Conclusion and Implications

In examining the relationships between a number of spaces, this paper extends Gremillion's argument by revealing how the space of a single side room reproduces the conflation of domestic spaces that are reconfigured at home. People with anorexia negate the myriad of social relations associated with food, and retreat to the privacy of bedrooms to eat alone. When admitted to hospital in-patient programs, participants transformed the clinical rooms and replicated the intimacy of their bedrooms, thus reproducing the practices of eating, sleeping and abluting in the one conflated space. Treating staff encouraged this transformation and reproduction by encouraging parents to bring in items from home, ensuring that participants ate alone, and not allowing activities outside of the room (unless participants gained weight). Unknowingly, the

programs effectively reproduced and supported the many isolating practices that people with anorexia use to negate relatedness.

Psychiatrists, allied health professionals and families recognise that anorexia is a serious disorder with a high morbidity and a significant lifetime mortality. Treatment is difficult and prolonged, and as a recent article in the *Lancet* found, the existing in-patient treatment programs are not improving outcomes (Ben-Tovim et al., 2001). While these programs have already been criticized for their narrow focus on weight and behaviour modification, this paper argues that the spatial and temporal configuration of bed programs reproduces the social isolation and negation of relatedness that is central to maintaining anorexia. Considering that participants repeatedly stated that anorexia was not solely concerned with food and weight, but a way of dealing with the complexity of social relations, it is surprising that such individualist programs remain the first choice of institutional in-patient care.¹³

Not all programs, however, operate on this model. One hospital in which I conducted fieldwork had ten different programs for people with eating disorders, the majority of which were out-patient based (only four in-patient beds were reserved for acute patients). There were several features of this program that stood in clear distinction to the hospital programs in their reproduction of anorexic practices. Firstly, this was a community residential program located in a large three storey heritage home in the suburbs of Vancouver. Residents participated in a community and this location changed the very nature of their identity (as they were not circumscribed by institutional walls they did not consider themselves to be patients) and their recovery process. The relationships between food and relatedness were central to this program,

and people learnt skills that would enable them to engage in social relationships when they left the program. These included shared preparation of food and cooking in the house kitchen, inviting friends and family members to share meals on certain nights, grocery shopping, participation in day-to-day running of the house, and eating out. This service could only be accessed by those who had physically and emotionally prepared for a four month stay through another supported program (which included reaching target weight prior to entering the program to circumvent competition between residents).

The location of this treatment program unsettled and shifted the spatial relations of institutionalized power. Moreover, therapeutic spaces which supported the practices of anorexia (such as isolation in single bedrooms and eating alone) were challenged in an environment that focused on the fundamental relationships between sociality and food. At the time of my fieldwork this residential program had not been evaluated. In light of the arguments put forward in this paper, a therapeutic model that positions itself in stark contrast to traditional models of care warrants much closer attention from both the clinical and academic worlds.

¹ Probyn (1987) and Eckermann (1994) similarly critique early feminist writers such as Orbach and Lawrence who have embraced Bruch's (1978) leanings 'towards a causal model of the media as directly responsible for all social ills, and anorexia in particular as a falling out from experiencing too much representation' (Probyn 1987: 203; Eckermann 1994: 92).

² Grosz (1994) makes a similar point concerning the close analogy between the body and the text (1994: 117). She also suggests that while Bordo's discussion of anorexia in terms of a psychology of self control is extremely useful, it risks duplicating the mind/body dualism and taking the body as a kind of natural bedrock on which psychological and sociological analyses may be added as cultural overlays (Grosz 1994: 145).

³ Foucault himself recognised the overemphasis on 'techniques of domination' in institutions and shifted his later work into 'technologies of the self' (Foucault 1980, cited in Miller 1993: 321-2, cf. Foucault 1990).

⁴ Dias' (2003) examination of women's pro-anorexia narratives in cyberspace also breaks from simple distinctions of public/private, as the very public space of the internet emerges as a private sanctuary in which the women can recount personal narratives yet remain completely anonymous.

⁵ While Malson (1998) acknowledges that 'a discourse is not simply a set of linguistic practices' (1998: 28), her methodology and analysis is informed by textual data from single, individual interviews, and not the embodied discourses that exist in the social practices of everyday life.

⁶ The small numbers of men involved in this project precludes an examination of the relationship between masculinity, anorexia and space.

⁷ Following standard ethnographic practice, pseudonyms have been used throughout this paper.

⁸ Although different people had different names for 'anorexia', throughout this thesis I refer to it as anorexia, as this is the diagnosis that each were given, a 'label' that profoundly affected people's lives. I recognise the desire of many to write this term away (Malson 1998: 144; Pembroke 1993; Eckermann 1994), but I could not ignore the symbolic power attached to such a word, and the strategies used to mobilise its worth. This is not to suggest that the label existed independently as a clinical entity, or that it was necessarily taken as a given (it was, at certain times, denied), but rather to point to the ways in which anorexia was mobilised and transformed by participants. Anorexia was more than a medical diagnosis; it was, amongst many things, an empowering state of being, a friend, an enemy, and a way of life (cf. Warin 2004).

⁹ This cultural construction of privacy is an important aspect of anorexia. How would Grant practice anorexia in the houses that Carsten describes in Langkawi, where houses are characterised by a general lack of division of interior space? (1995: 113). Houses usually consist of a hearth and one main room, and individual household members do not have their own daytime space.

¹⁰ During my fieldwork the lead singer (Daniel Johns) of a three piece Australian band *Silverchair* wrote a song — *Ana's song* — about his experiences of anorexia. His experiences, and his ability to 'articulate' them through music, were seen to embody what was unspeakable about anorexia.

¹¹ One participant, who had experienced repeated sexual abuse, reported that anorexia was a way of disappearing and remaining silent, thus not attracting further unwanted attention.

¹² Longhurst (2001) makes a similar argument in her analysis of pregnant bodies and 'confinement'.

¹³ Gremillion notes that whilst programs have changed considerably in the last decade, that 'many practitioners today idealise programs like the one I studied [long term in-patient hospitalisation] and strive (or wish) to emulate its practices and principles as much as possible. Also, the centrepiece of most 'pared down' hospital programs remains, not surprisingly, weight gain through behaviour modification. In fact, some hospital programs are now narrowing to this focus'. (2003: 11)

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